

**MILFORD HOSPITAL
POLICY AND PROCEDURES
FINANCIAL ASSISTANCE POLICY (FAP)**

POLICY:

Milford Hospital is committed to providing financial assistance to persons who have healthcare needs and are uninsured, underinsured, ineligible for a government program or otherwise unable to pay for emergency or other medically necessary care based on their individual financial situation. Milford Hospital will provide, without discrimination, care of emergency medical conditions to individuals regardless of their ability to pay, their eligibility for financial assistance or for government assistance. This policy limits the amount the hospital will charge for emergency or other medically necessary care provided to individuals eligible for financial assistance.

I. ELIGIBILITY FOR FINANCIAL ASSISTANCE:

- A. The Hospital will consider all individuals who are uninsured, underinsured, ineligible for any government health care benefit program, and who are unable to pay for their care, based upon a determination of financial need, and shall not take into account age, gender, race, social or immigrant status, sexual orientation or religious affiliation.
- B. Criteria for determining eligibility and the amount of financial assistance for which the patient is eligible will include family income, family size, family net worth and any other pertinent information.
- C. Presumptive Financial Assistance Eligibility may be assumed for individuals in extenuating circumstances. In some cases an individual may appear to be eligible for financial assistance, but there is no financial assistance form on file due to lack of supporting documentation. The Hospital may use information from outside agencies to estimate income amounts and determine eligibility. The Hospital may determine presumptive eligibility based on an individual's life circumstances including, but not limited to:
 - 1. State funded prescriptions programs;
 - 2. Lives in a homeless shelter;
 - 3. Food stamp eligibility;
 - 4. Subsidized school lunch program;
 - 5. Eligible for Medicaid spend-down;
 - 6. Lives in low income subsidized housing; and
 - 7. Patient is deceased with no known estate.

II. BASIS FOR DISCOUNTING HOSPITAL CHARGES:

The basis for the amounts Milford Hospital will charge patients qualifying for financial assistance is as follows:

- A. Patients whose family income is equal to or less than 250% of the Federal Poverty Level (FPL) may qualify for up to a 100% discount off of their outstanding balance. (Please see E below.)
- B. Patients whose family income is between 250% and 400% of the FPL, in accordance with the requirements of IRS Section 501(r)(5), may have charges limited to the Amounts Generally Billed (AGB) to individuals who have insurance for such care. The amounts billed to those who qualify for financial assistance will be based on an average of the three best, negotiated commercial rates. (Please see F below.)
- C. Patients whose family income exceeds 400% of the FPL may be eligible to receive discounted rates on a case-by-case basis based on extenuating circumstances. Specific circumstances may include catastrophic illness, medical indigence or other financial hardship circumstances at the discretion of Milford Hospital. The discount will not be more than the discount received by patients who have insurance for such care.
- D. Patients who qualify for presumptive financial assistance may qualify for a 100% discount off their outstanding balance.
- E. Patients who have assets that are greater than 250% of the FPL and family income that is less than or equal to 250% of the FPL will have their charges limited to the AGB to individuals with insurance.
- F. Patients who have assets that are greater than 250% of the FPL and family income that is greater than 250% of the FPL may be denied financial assistance.

III. METHOD FOR APPLYING FOR FINANCIAL ASSISTANCE:

- A. A request for financial assistance can be made before services are received and up to six months after and will be in effect for six months forward from the date of the approved application. The request may be made by or “on behalf” of an individual seeking services from our hospital. A request for financial assistance can be made at any time during the collection process. Requests received after an account has been turned over to an external collection agency and/or attorney, will be recalled from the external party pending determination on the patient’s eligibility for assistance. Milford Hospital may request updated financial information at any time and adjust the financial assistance accordingly.
- B. Patients may inquire about our Financial Assistance program from Patient Registration, Social Services, or by calling a Milford Hospital credit representative at 203-876-4474.
- C. The patient must submit the following documentation with a completed Financial Assistance application:
 1. Most recent Federal Tax Return and W-2.
 2. Most recent 3 payroll checks or unemployment checks.

3. Copies of pension, alimony, child support, social security or any other sources of income.
 4. Copies of bank statements for the past 2 months.
 5. Any other pertinent information.
- D. Applications that are not completed and returned to the Hospital with the appropriate documentation within 30 days after the application was mailed to them will be denied.
 - E. Completed applications will be reviewed to determine patient's eligibility for assistance.
 - F. Milford Hospital will make every attempt to notify patients of the determination of their application within 30 days of receipt of a completed financial assistance application and supporting documentation.
 - G. Patients granted assistance will be given 30 days to make full payment or make payment arrangements approved by Milford Hospital. If full payment is not received within 30 days or an acceptable payment arrangements has not been agreed to, the account may be returned to an external agency for collection.

IV. COMMUNICATIONS TO PUBLIC OF HOSPITAL'S FAP:

- A. Notification of the availability of Financial Assistance will be posted in the following areas of the Hospital in both English and Spanish:
 1. Admitting
 2. Emergency Department
 3. Billing/Credit Office
 4. Social Services
- B. A credit department representative will meet with self-pay inpatients to explain the Hospital's financial assistance policy. If the representative is unable to meet with the patient, the patient will be given financial assistance paperwork.
- C. All self-pay patients will receive a, "Patient Notice on Financial Assistance," with their first billing statement.
- D. The financial assistance policy will be posted on Milford Hospital's website.
- E. Reference to the Hospital's financial assistance policy will be made on materials available in the community when appropriate.
- F. Applications and additional information are available by calling a Milford Hospital credit representative at 203-876-4474.

**MILFORD HOSPITAL
POLICY AND PROCEDURES
CREDIT & COLLECTION BAD DEBT**

Purpose: The primary mission of Milford Hospital is to provide the highest quality medical care to its patients at the lowest cost. An efficient and equitable system must be established that will maximize the collection of patient accounts receivable balances in order to provide the cash flow required to operate Milford Hospital effectively.

PROCEDURE:

These Collection Policies and Procedures apply to all accounts. Collection/follow-up work will be prioritized on the basis of largest balance. All rejected third parties will also be classified as self-pay until such time as further insurance is verified.

The statements and credit letters are computer generated according to the schedules outlined below. Accounts will be transferred to the appropriate billing class whenever payments or rejections are received from third party payers. Specific policies and procedures vary with classification of the account as follows:

- A. **Pending Financial Assistance**
During hospitalization, Collection Staff will attempt to explain the SAGA application procedure, and provide the appropriate Department of Social Services address and telephone number.

- B. **Non-Contractual and Self-Pay Accounts:**
Follow-up on these cases will be as follows:

| <u>Days After Billing</u> | <u>Procedures</u> |
|----------------------------------|---|
| 45 | First statement |
| 75 | Second statement |
| 105 | Final notice sent to patient |
| 135 | Turnover to Collection Agency or Attorney |

In addition to the above, scheduled telephone contact will be initiated.

Self-Pay Residual

Residual balances after third party payment/rejection will proceed through the appropriate statements, message, letters and phone calls as follows:

- 1) The day after all third parties are satisfied (paid or rejected), a statement showing the charges, credits and payments applicable thereto and the

- resulting self-pay balance will be produced and mailed to the patient.
- 2) The account will advance through the non-contractual accounts cycle outlined above.
 - 3) In all cases, the cycle detailed for all accounts can be interrupted by one or more of the following occurrences:
 - a) Receipt and verification of third party coverage.
 - b) Payment arrangements are agreed to and followed by the patient/guarantor.
 - c) Evidence that the account is uncollectible, a history of bad debt accounts, or other legal consideration may result in an expedited referral to an agency or attorney.

C. **General Policies**

- 1) Several general policies have been established to control the activities in the collection cycle.
- 2) Whenever possible, arrangements with local banks, credit union or the finance company for loans to the patient should be secured to relieve the hospital from the collection process.
- 3) Minor balances, under \$5.00, should be automatically written off 30 days after discharge if no response is received from the patient.
- 4) Accounts identified as referrals to agencies or attorneys, and accounts directly written off will be reviewed and approved by the Manager and/or Director of Patient Accounts.

D. **Medicare**

- 1) At time of pre-registration and/or registration of patient, all registration personnel will verify the patient's Medicare coverage and confirm Medicare as the primary payer.
- 2) The Medicare MSP questionnaire will be completed via the registration program.
- 3) *Patients will be notified in writing at the time of registration of Medicare covered services that will not be covered during this episode of care, lack of medical necessity, will be issued an Advance Beneficiary Notice (ABN).*